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Office of Administrative Law Judges
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Issue date: 30Oct2002

Case No. 2001-BLA-649

In the Matter of
LASTEL LEWIS,
Claimant,

v.

ISLAND CREEK COAL COMPANY,
c/o ACCORDIA EMPLOYERS SERVICE
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:[1]
Ronald K. Bruce, Esq.
Madisonville, Kentucky
For the Claimant

Stuart Bennett, Esq. for
Martin Hall, Esq.
Lexington, Kentucky
For the Employer

BEFORE: HON. THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

[1] The Director, Office of Workers' Compensation Programs, was not present or represented at the hearing.

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, (hereinafter referred to as "the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[2]

On April 9, 2001, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (Dir. Ex. 41, 42).[3] A formal hearing on this matter was conducted on December 4, 2001, in Madisonville, Kentucky, by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations. The Employer's Closing Argument was received on March 4, 2002. The Brief on Behalf of the Claimant was received on March 7, 2002.

ISSUES

The issues in this case are:

1. Whether the claim was timely filed;

2. Whether the miner has pneumoconiosis as defined by the Act and regulations;

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[2] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80,045-80,107(2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, U.S. District Court Judge Emmet Sullivan issued a Memorandum and Order upholding the validity of the new regulations. *National Mining Association v. Chao*, No. 00-3086 (D.D.C. Aug. 9, 2001). However, the United States Court of Appeals for the District of Columbia Circuit ("the court") affirmed in part, reversed in part, and remanded the case. *See National Mining Association v. Department of Labor*, No. 01-5278 (June 14, 2002). Accordingly, I will apply the sections of the newly revised version of Parts 718 and 725 that took effect on January 19, 2001 that the court did not find impermissibly retroactive.

Pursuant to § 725.2(c), the revisions of this part [Part 725] shall also apply to the adjudication of claims that were pending on January 19, 2001, except for the following sections: § 725.309, 725.310, etc. (see the C.F.R. for the complete list of exempted sections).

Pursuant to § 718.101(b), the standards for the administration of clinical tests and examinations contained in subpart B "shall apply to all evidence developed by any party after January 19, 2001 in connection with a claim governed by this part [718]**...**" (emphasis added).

[3] In this Decision, "Dir. Ex." refers to the Director's Exhibits, "Er. Ex." refers to the Employer's Exhibits, "Cl. Ex." refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding.

3. Whether the miner's pneumoconiosis arose out of coal mine employment;

4. Whether the miner is totally disabled;

5. Whether the miner's disability is due to pneumoconiosis; and

6. Whether the miner has established a material change in conditions, pursuant to §725.309(d), since the denial of his previous claim.

(Dir. Ex. 41; Tr. 12-13). The issues of constitutionality, liability for legal and medical expenses, unavailability of comparable work, and whether the medical tests meet regulatory standards, were raised for appellate purposes.

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT

Procedural History

Lastel Lewis ("Mr. Lewis" or "Claimant") filed his application for Black Lung benefits on March 7, 2000. (Dir. Ex. 1). On June 19, 2000, the Director, Office of Workers' Compensation Programs ("OWCP") initially denied benefits, a decision the Claimant appealed. (Dir. Ex. 18, 19). On March 28, 2000, the OWCP designated Island Creek Kentucky Mining ("Employer") as the putative responsible operator. (Dir. Ex. 22, 21). Employer controverted liability on April 3, 2000. (Dir. Ex. 23). On February 7, 2001, the OWCP awarded benefits to Mr. Lewis. (Dir. Ex. 33). Employer appealed the decision on February 14, 2001, and requested a formal hearing before the Office of Administrative Law Judges ("OALJ"). (Dir. Ex. 34, 35). On February 21, 2001, the Black Lung Disability Trust Fund began paying benefits in the interim. (Dir. Ex. 36). The case was forwarded to the OALJ on April 9, 2001. (Dir. Ex. 41, 42). The undersigned presided over the hearing on December 4, 2001.

The Claimant's previous claim, filed on October 23, 1989, was denied on April 2, 1990 by the OWCP. The OWCP determined that neither pneumoconiosis, total disability, nor causation were established.

Background:

Mr. Lewis was seventy-three years old at the time of the hearing, and has an eighth grade education. He is married. (Dir. Ex. 1, 9).

Mr. Lewis testified that he smoked until approximately eleven or twelve years ago. He smoked one-half to one pack of cigarettes per day for forty-five years. (Tr. 23-24; *see also* Claimant's Answers to Interrogatories, Er. Ex. 7).

Responsible Operator:

Island Creek is the employer with whom Mr. Lewis spent his last cumulative one year period of coal mine employment and is properly designated as the responsible operator in this case. §725.493(a)(1); (Dir. Ex. 2, 3, 4, 6, 7).

Length of Coal Mine Employment:

Mr. Lewis was a coal miner within the meaning of § 402(d) of the Act and § 725.202 of the regulations. The parties stipulated he had at least forty-one years of qualifying coal mine employment. (Tr. 13). I accept this stipulation as supported by the evidence of record. (Dir. Ex. 2, 4, 5, 6, 7). Mr. Lewis testified that all of his unemployment was underground, and that he last worked on September 1, 1989 as a supply man for the named Employer. (Tr. 15; Dir. Ex. 3).

Dependents:

Mr. Lewis has one dependent for purposes of augmentation of benefits awarded under the Act and regulations, his wife. (Dir. Ex. 1, 9).

MEDICAL EVIDENCE

The following is a summary of all the medical evidence of record:

Chest X-rays:

X-ray Date	Exhibit Number	Physician/Qualifications[4]	Reading
12/4/89	Dir. Ex. 40.12	Traughber/"A" reader	1/0, s/t, mid and lower zones.
12/4/89	Dir. Ex. 40.13	Sargent/"B" reader, BCR	0/0. Smoking history?
5/2/00	Dir. Ex. 15	Galuten	Mild reticulonodular pattern in both lungs. Mild hyperinflation.*
5/2/00	Dir. Ex. 15	Simpao	1/1, p, 6 zones.
5/2/00	Dir. Ex. 16, 17	Sargent/"B" reader, BCR	0/0. Smoking history? Granuloma?
5/2/00	Dir. Ex. 26, Er. Ex. 4	Wheeler/"B" reader, BCR	0/0.
5/2/00	Er. Ex. 1, 4	Wiot/"B" reader, BCR	0/0. A calcified granuloma left base.
5/2/00	Er. Ex. 1	Morgan	0/0. Possible granuloma.
12/6/00	Dir. Ex. 27	Sellers/"B" reader	0/0. Old healed granulomatous disease.
12/6/00	Dir. Ex. 32	Wiot/"B" reader, BCR	0/0. Calcified granuloma left base.
12/6/00	Dir. Ex. 37, Er. Ex. 4	Spitz/"B" reader, BCR	0/0. Calcified granuloma left base.

[4] The curriculum vitae of most of these physicians were not admitted in the record. However, the record does indicate their qualifications, and by confirming this with the NIOSH "B" reader list and Board certification compilations, I take judicial notice of the physicians' qualifications.

12/6/00	Dir. Ex. 38, Er. Ex. 4	Scott/"B" reader, BCR	0/0. Em? Calcified granuloma LLL.
12/6/00	Dir. Ex. 38	Wheeler/"B" reader, BCR	0/0. Em? Small calcified granuloma LLZ.
12/6/00	Dir. Ex. 39	Castle/"B" reader	Calcified granuloma LLZ.
5/11/01	Cl. Ex. 1	Whitehead/"B" reader, BCR	0/1, q, 1 zone.
5/11/01	Er. Ex. 13	Wheeler/"B" reader, BCR	0/0. Chest surgery. Em? Small calcified granuloma.
5/11/01	Er. Ex. 13	Scott/"B" reader, BCR	0/0. Chest surgery. 8 mm LLL calcified granuloma.
5/11/01	Er. Ex. 13	Wiot/"B" reader, BCR	0/0. Chest surgery. Calcified granuloma. Disc atelectasis.
5/11/01	Er. Ex. 14	Castle/"B" reader	Previous chest surgery.
5/11/01	Er. Ex. 15	Spitz/"B" reader, BCR	0/0. LLL calcified granuloma.
8/15/01	Cl. Ex. 1	Baker[5]	1/0, p, 3 zones. Probable granulomas, post-op changes.
8/15/01	Er. Ex. 16	Wiot/"B" reader, BCR	0/0. LLL calcified granuloma.
7/26/01	Er. Ex. 9	Lundquist	COPD. Cannot exclude

[5] Dr. Baker checked off that he was not a B-reader when this x-ray was reviewed by him on August 15, 2001. The June 1999 NIOSH B-Reader List, viewable at www.oalj.dol.gov, has him listed as a B-reader through January 31, 2001. Although the NIOSH web site indicates that Dr. Baker is currently a B-reader, it does not give a beginning date for the current certification.

mass.#

* As this reading was not classified in accordance with the ILO/UC system, it is unknown whether it would be considered positive or negative under the Act.

There is no indication that this x-ray was read for the presence or absence of pneumoconiosis.

Pulmonary Function Tests:

Date	**Ex. No.**	**Age/ Height**	**FEV1[6]**	**FVC[7]**	**MVV[8]**	**Valid**	**Qualifies**
12/4/89	Dir. Ex. 40.9	61/68"	0.91	2.77	32.5	No	Yes
5/2/00	Dir. Ex. 10	72/67"	1.48	2.72	43.0	Yes[9]	Yes
7/25/00	Dir. Ex. 24, 25	72/67"	1.23	2.38	42	Yes[10]	Yes

[6] Forced expiratory volume in one second.

[7] Forced vital capacity.

[8] Maximum voluntary ventilation.

[9] The comments to the 5/2/00 study indicate that the data is acceptable and reproducible; the patient effort, cooperation and comprehension were good; and that matches were obtained for the FEV1 and FVC. (Dir. Ex. 10).

Dr. N.K. Burki, who is board-certified in internal and pulmonary medicine, reviewed the 5/2/00 study and found it to be invalid based on less than optimal effort, cooperation and comprehension. He stated that the "curve shapes indicate suboptimal effort." (Dir. Ex. 11, 12).

Dr. W.K.C. Morgan's review was inconclusive. (Er. Ex. 2). Dr. James Castle opined that the tests appeared to be valid. (Er. Ex. 3).

[10] Dr. Morgan's review concluded that "Dr. Burki states that the ventilatory tests carried out by Dr. Simpao on 07/25/00 are acceptable. I think he is being a little lenient but they are certainly much better than the prior tests." (Er. Ex. 2). Dr. Castle opined that the test appeared to be valid. (Er. Ex. 3).

12/6/00	Dir. Ex.	72/69"							
	27, 28	Pre-rx		1.30	2.36	40		Yes[11]	Yes
		Post-rx		1.56	2.74	39		Yes	Yes
5/11/01	Cl. Ex.	73/67"							
	1		Pre-rx		1.06	2.09	33.6		Yes[12] Yes
		Post-rx		1.19	2.71	34.0		Yes	Yes
8/15/001	Cl. Ex.	73/67"							
	1		Pre-rx		1.16	2.42	41		Yes[13] Yes
		Post-rx		1.28	3.02	48		Yes	Yes

Arterial Blood Gas Studies:

Test Date	**Exhibit No.**		**pCO2**	**pO2**	**Qualifies**
12/4/89	Dir. Ex. 40.11		42.0	76.0	No
		(e)	38.4	109.4	No
5/2/00	Dir. Ex. 14		43.2	73.3	No
12/6/00	Dir. Ex. 27		46.3	78.6	No
		(e)	39.6	86.8	No
10/24/01	Er. Ex. 6, 10		46	67	No

(e) Results obtained with exercise.

Medical Opinions:

Dr. Sam Traughber examined the Claimant on December 4, 1989 on behalf of the OWCP. He reviewed the Claimant's histories, symptoms, and medications. The Claimant was still

[11] Dr. Lombard found it to be valid. Dr. N.K. Burki found it to be invalid. (Dir. Ex. 27, 28). Dr. Morgan found some measurements valid, some not. (Er. Ex. 2). Dr. Castle concluded that the test appeared to be valid. (Er. Ex. 3).

[12] The computer interpretation of the May 11, 2001 study says "[l]ow FEV 0.5 suggests poor initial effort. MVV low relative to FEV1; suggest poor effort and/or neuromuscular disorder." (Cl. Ex. 1).

[13] Dr. Castle concluded that the study appeared "to be valid, although there is some variability in the forced vital capacity maneuver." (Er. Ex. 10).

smoking at that time. Examination of the chest was normal. An x-ray was positive for pneumoconiosis, 1/0. Due to the study's invalidity, a severe obstructive ventilatory defect could not be verified. An arterial blood gas test was normal, as was an EKG. Dr. Traughber diagnosed coal workers' pneumoconiosis based on the x-ray, which he related to coal mine dust exposure. He also noted the Claimant's nicotine addiction. Dr. Traughber stated that "the patient has a moderate impairment though I cannot document it with his current test. His exercise gases would indicate that he has fairly good functioning at this level. However, with sustained exercise I think he would probably have difficulty." As to etiology of the impairment, he stated that "I cannot apportion the amount due to his cigarette smoking and the amount due to dust in the coal mines." (Dir. Ex. 40.10).

Dr. Valentino S. Simpao examined the Claimant on May 2, 2000 on behalf of the OWCP. He reviewed the Claimant's histories, symptoms, and medications. Examination revealed increased resonance in the upper chest and axillary areas, crepitation, distant breath sound, and inspiratory and expiratory wheezes, as well as slightly cyanotic lips and nails. An x-ray was positive for coal workers' pneumoconiosis, 1/1. A pulmonary function study showed a moderate degree of reversible and a severe degree of obstructive airway disease. An arterial blood gas test revealed ventilatory perfusion mismatch with borderline hypoxia. An EKG revealed inverted T waves in V-2 through V-6 suggestive of ischemia versus subendocardial infarction with nonspecific ST-T changes. Dr. Simpao diagnosed CWP 1/1. He stated that the "[m]ulti years of coal dust exposure is medically significant in his pulmonary impairment," which he deemed moderate. Dr. Simpao further stated that the Claimant was totally disabled based on the "[o]bjective findings on the chest x-ray, arterial blood gas, EKG, pulmonary function test along with symptomatology and physical findings as noted in the report." (Dir. Ex. 13).

The records of Regional Medical Center show that the Claimant was hospitalized from May 10 to 14, 2000 for a cardiac catheterization, direct myocardial revascularization with grafts, and atrial pacing wire. The discharge diagnoses were severe coronary artery disease with unstable angina, and chronic obstrutive pulmonary disease ("COPD"). Four portable and one PA/LAT chest x-rays were taken while the Claimant was hospitalized; none of them were read for the presence or absence of pneumoconiosis. (Er. Ex. 9).

Dr. Robert M. Lombard, Jr. examined the Claimant on December 6, 2000, and issued a report on December 13, 2000. He also reviewed the Claimant's histories, symptoms, and medications. Examination revealed that the lungs were resonant to percussion. Breath sounds were distant with faint scattered wheezes bilaterally but overall airflow was relatively well preserved. A pulmonary function study was consistent with moderate airflow limitation and air trapping, with a significant response to bronchodilator. The diffusing capacity was normal. A complete blood count ("CBC"), an arterial blood gas test, and a pulmonary stress test were also obtained. He read an x-ray as positive for old granulomatous disease but negative for CWP. Dr. Sellers, a B-reader, also read the x-ray as negative. Dr. Lombard concluded that the Claimant did not have coal workers' pneumoconiosis based on the negative x-ray. He found a moderate degree of COPD, and due to the reversibility, found a substantial portion of that COPD to be asthma. He

further stated that he does "not believe his work history had anything to do with his development of COPD. His cigarette smoking would be a contributing factor but in light of the degree of reversibility he has, he may also have developed this problem 'de novo'." He found the Claimant to be totally disabled. (Dir. Ex. 27).

Dr. Maan Younes reviewed medical records on behalf of the OWCP and filled out a questionnaire on January 23, 2001. He stated that the Claimant "has severe obstructive impairment to which working in the coal mines for 41 years contributed significantly," and moreover that "[i]t is caused by a combination of smoking history and history of working in the coal mines for 41 years." He also checked off that the Claimant could not perform comparable work in a dust-free environment. (Dir. Ex. 31). Dr. Younes is board-certified in internal and pulmonary medicine. (Cl. Ex. 2).

Dr. W.K.C. Morgan reviewed medical records on behalf of the Employer and issued a report on April 2, 2001. He concluded that the Claimant "has not had a prolonged exposure to coal mine dust," calculating only nine years underground with only a relatively short time being spent at the coal face" and "virtually all of [that] time **...** [being] after the passage of the Federal Coal Mine Health and Safety Acts of 1969 and 1972." He stated that the "few scanty irregular opacities in the lower zones **...** cannot in any way be attributed to his former job in the coal mines, and are almost certainly a consequence of his cigarette smoking." He related the mild to moderate airways obstruction to cigarette smoking as well. As to the restrictive impairment, he stated that it "probably antedated his coronary artery surgery but became worse following the surgery. Splitting open the chest always leads to a reduction of the ventilatory capacity with both the FEV1 and FVC being involved. There is nothing to suggest that Mr. Lewis had any restrictive impairment prior to that." He considered Dr. Taughber's and Dr. Simpao's lung function tests to be invalid. He noted the normal arterial blood gas tests, and commented that "[i]f his airways obstruction was severe one would expect his PO2 to fall during and following exercise." Dr. Morgan also concluded that "Mr. Lewis had been economical as far as his smoking history is concerned and he has probably smoked appreciably more." He stated that "[t]he obstruction was either absent or mild in 1989 but became progressively worse after the age of 60 years. This is a common finding in somebody who is a cigarette smoker who develops emphysema." Dr. Morgan found no objective evidence of CWP, and that the Claimant "is totally and permanently disabled, mainly because of his age, but also because he has coronary artery disease which is still causing symptoms, namely, dyspnoea (sic) and chest pain, and he also has some airways obstruction. Were it not for his age and coronary artery disease, he could have probably continued working as a pumper in the mine." (Er. Ex. 2).

Dr. William C. Houser interviewed and examined the Claimant on May 11, 2001. The smoking history was approximately forty-five pack years. Examination revealed diminished breath sounds, a prolonged expiratory phase, and some scattered rhonchi and wheezing primarily on expiration. An x-ray was read as 0/1. A pulmonary function study showed severe airway obstruction with modest response to bronchodilator administration. There was a severe reduction in the MVV with no response to bronchodilator administration. Dr. Houser diagnosed severe COPD and arteriosclerotic heart disease, status post coronary bypass surgery. He concluded that the COPD was due to both cigarette smoking and coal and rock dust exposure, with the latter being a significant contributing factor. He cited to an article published in The American Journal of Respiratory and Critical Care Medicine, which set forth exposure to occupational dust as a cause of COPD, including reductions in the FEV1 despite no radiographic evidence of pneumoconiosis. The article also set forth nonmalignant respiratory diseases including COPD (emphysema and chronic bronchitis) and coal workers' pneumoconiosis as a cause of premature deaths among coal miners. Dr. Houser concluded that "[b]oth cigarette smoking and exposure to coal mine dust are associated with abnormal pulmonary function and in some cases marked reduction in function similar to that observed in Mr. Lewis' case." (Cl. Ex. 1).

Dr. James R. Castle also reviewed much of the medical records on behalf of the Employer. He issued a report on May 31, 2001. Dr. Castle concluded that Mr. Lewis did not "demonstrate any consistent findings indicating the presence of an interstitial pulmonary process," but "did have reduced breath sounds consistent with tobacco smoke induced airway obstruction or bronchial asthma." He noted that his and the majority of x-ray readings were negative for coal workers' pneumoconiosis. Setting forth that coal workers' pneumoconiosis causes a mixed, irreversible obstructive and restrictive ventilatory defect, Dr. Castle attributed the moderate degree of airway obstruction with a very significant degree of reversibility after bronchodilators to tobacco smoke induced chronic airway obstruction with a very significant asthmatic component to it. He noted the normal arterial blood gases at rest and after exercise. Dr. Castle concluded that Mr. Lewis does not suffer from coal workers' pneumoconiosis, but he found him to be totally disabled. (Er. Ex. 3). Dr. Castle is board-certified in internal and pulmonary medicine. (Er. Ex. 4).

Similarly, Dr. Thomas M. Jarboe reviewed some medical records on behalf of the Employer, and issued a report on June 3, 2001. He concluded that the x-rays were negative for pneumoconiosis, and that the evidence as a whole was negative for pneumoconiosis. He explained that while the spirometric pattern "could be seen in a dust induced lung disease," the lack of restriction (as evidenced by the lack of reduction in FVC and the preservation of the total lung capacity) and the significant reversible component to the airflow obstruction, argued against a relationship. He stated that "[t]he presence of reversible airflow obstruction argues for causation by another etiology, for example cigarette smoking and/or bronchial asthma itself." Dr. Jarboe further pointed out that coal miners can "have minor degrees of elevation of their residual volume," not the amount seen in this case (157% of normal) "without more evidence of dust retention in the lungs." Dr. Jarboe, however, found the

Claimant to be totally disabled from a respiratory standpoint. He is board-certified in internal and pulmonary medicine. (Er. Ex. 4).

On July 6, 2001, Dr. Houser wrote that Mr. Lewis is permanently and totally disabled due to severe chronic obstructive pulmonary disease, and that the "coal and rock dust arising from his former employment as a coal miner is a significant contributing factor." Dr. Houser is board-certified in internal, pulmonary, and critical care medicine. (Cl. Ex. 1).

On July 25, 2001, Dr. Lawrence Repsher issued a report on his review of medical records on behalf of the Employer. Dr. Rephsher stated that since the Claimant "failed to provide even a modicum of patient effort and cooperation," that "the pulmonary function tests are uninterpretable for the presence of pulmonary disease." He then stated that the normal arterial blood gas test results "essentially [rule] out any clinically significant interstitial lung disease, such as coal workers pneumoconiosis." Dr. Repsher found the x-ray readings negative for pneumoconiosis, and could not state whether the Claimant had any pulmonary disease. Dr. Repsher is board-certified in internal, pulmonary and critical care medicine. (Er. Ex. 5).

Dr. Glen R. Baker, Jr. interviewed and examined the Claimant on August 15, 2001. The Claimant was on Proventil, Serevent and Theophylline for his pulmonary complaints. Examination revealed clear lungs. An x-ray was positive for pneumoconiosis, 1/0. Pre- and post-bronchodilator pulmonary function studies revealed a moderate obstructive ventilatory defect. The approximately 10% improvement in the FEV1 suggested some degree of bronchospasm present but no distinct reversibility. Dr. Baker diagnosed coal workers' pneumoconiosis, category 1/0, based on the abnormal x-ray and the significant history of dust exposure; chronic obstructive airway disease with moderate obstructive ventilatory defect with mild improvement following bronchodilators, based on the pulmonary function testing; chronic bronchitis, based on history; and ischemic heart disease, based on history and the physical examination. He stated that the "[p]atient has abnormal x-rays and a significant history of dust exposure and no other condition to account for these x-ray changes," and that the "[p]atient has a 12-13 pack year history of smoking and a 41-year history of dust exposure along with x-ray evidence of pneumoconiosis. It is thought that any pulmonary impairment is caused at least in part, if not significantly so, by his coal dust exposure." As to the extent of impairment, Dr. Baker explained that the "[p]atient has a Class 3 impairment based on the FEV1 between 41% and 59% of predicted. This is based on Table 5-12, Page 107, Chapter Five, Guides to the Evaluation of Permanent Impairment, Fifth Edition." He further stated that the "[p]atient has a second impairment based on Section 5.8, Page 106, Chapter Five, Guides to the Evaluation of Permanent Impairment, Fifth Edition, which states that persons who develop pneumoconiosis should limit further exposure to the offending agent. This would imply the patient is 100% occupationally disabled for work in the coal mining industry or similar dusty occupations." (Cl. Ex. 1).

On September 25, 2001, Dr. Baker restated that the diagnoses and that the Claimant was totally disabled with a Class 3 impairment based on the FEV1 being between 41% and 59%. Dr. Baker is board-certified in internal and pulmonary medicine. (Cl. Ex. 1).

Dr. David A. Jarvis interviewed and examined the Claimant on October 24, 2001 on behalf of the Employer. The smoking history was one-half pack of cigarettes per day, none in the past twelve years. Examination revealed moderate decrease in breath sounds bilaterally with 2+ wheezes and rhonchi bilaterally. An x-ray showed hyperinflation compatible with emphysema with blunting of the right costophrenic angle. An arterial blood gas test was obtained. A pulmonary function study showed severe obstructive pulmonary impairment. Dr. Jarvis's impression was severe COPD with bronchospasm, ischemic heart disease, mild obesity, and coal dust exposure. He concluded that "Mr. Lewis does appear to have advanced COPD almost certainly from his previous tobacco habit. I see no evidence of coal worker's pneumoconiosis and believe all of his pulmonary disease can be explained on smoking, COPD and wheezing." Dr. Jarvis is board-certified in internal, pulmonary and sleep medicine. (Er. Ex. 6, 10).

On November 7, 2001, Dr. Repsher reviewed Dr. Baker's report. He noted that "Dr. Baker, as usual, finds his chest x-ray positive for coal workers pneumoconiosis (p/p 1/0)" and that "it has been [his] experience that Dr. Baker finds most, if not all, chest x-rays to be positive for coal workers pneumoconiosis." He then criticized Dr. Baker for finding an impairment when he considered the pulmonary function tests uninterpretable for the presence of pulmonary disease. (Er. Ex. 8).

Dr. Morgan also reviewed Dr. Baker's report and issued a report on November 7, 2001. His conclusions remained the same. In response to the low pack year history given to Dr. Baker, Dr. Morgan stated that "[c]learly Mr. Lewis has been an heavy cigarette smoker for most of his life and has been extremely economical with the truth in regard to his smoking history." (Er. Ex. 9).

Dr. Castle issued a supplemental report on November 12, 2001 after reviewing Dr. Baker's report. His opinions remained the same. (Er. Ex. 10).

Depositions:

Dr. Jarvis was deposed on November 15, 2001. He testified that tobacco is the main irritant that causes COPD, "although many people can develop COPD without smoking," and that "[t]he obstructive defect is very, very minimal in coal workers' pneumoconiosis." (Er. Ex. 10).

Dr. Jarboe was deposed on November 20, 2001 after reviewing additional medical records. His opinions remained the same. (Er. Ex. 11).

Dr. Castle was deposed on November 27, 2001. He testified that chronic airway obstruction due to coal mine dust exposure can arise as an acute effect, while someone is exposed, which "generally abates and goes away". It can also arise as "an irreversible type of obstruction" which is generally not severe and may be associated with some decline in lung volumes as well. (Er. Ex. 12).

DISCUSSION

Applicable Law:

Mr. Lewis' claim was filed after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, the following elements:

1. That he suffers from pneumoconiosis;

2. That the pneumoconiosis arose, at least in part, out of coal mine employment;

3. That the claimant is totally disabled; and

4. That the total disability is caused by pneumoconiosis.

See §§ 718.3, 718.202, 718.203, 718.204; *Gee v. W.G. Moore*, 9 B.L.R. 1-4, 1-5 (1986); *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-212 (1985). Failure to establish any of these elements precludes entitlement. *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26, 1-27 (1987).

Subsequent Claim:

The instant claim was filed more than one year after the final denial of the Claimant's original claim, which brings it under the governance of § 725.309(d). Section 725.309(d) dictates that "if the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless **. . .** there has been a material change in conditions." The United States Court of Appeals for the Sixth Circuit, under whose appellate jurisdiction this claim arises, has articulated the standard to be followed in determining whether a miner has established a "material change in conditions" in the context of a duplicate claim. In *Sharondale Corp. v. Ross*, the Sixth Circuit ruled that,

> [T]he ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then the ALJ

must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

42 F.3d 993, 997-98 (6th Cir. 1994).

Evidence submitted after the previous denial of benefits will be analyzed first to determine whether such evidence establishes a material change in conditions. Previously, Claimant failed to establish any element of entitlement. Therefore, a material change in conditions will exist if the newly submitted evidence establishes at least one element of entitlement previously adjudicated against the Claimant. For continuity of reading, the analysis will begin with total disability.

Total Disability:

If Claimant is to prevail, he must demonstrate that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis pursuant to one of the five standards of § 718.204(c) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under Section 718.204(c), all relevant probative evidence, both "like" and "unlike" must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

There is no evidence of complicated pneumoconiosis in the record. Therefore, the irrebuttable presumption of § 718.304 does not apply and total disability cannot be shown under § 718.204(b).

Total disability can be shown under § 718.204(c)(1) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. A qualifying result was achieved on five occasions. Therefore, I find that Claimant has established total disability under § 718.204(c)(1).

Total disability can be demonstrated under § 718.204(c)(2) by the results of arterial blood gas studies. The ABG studies that were performed failed to yield a qualifying result. Therefore, total disability cannot be shown under § 718.204(c)(2).

Total disability may also be shown under § 718.204(c)(3) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. There is no medical opinion in the record that Claimant suffers from this condition. Therefore, I find that Claimant has not established total disability under subsection (c)(3).

Section 718.204(c)(4) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that Claimant's respiratory or pulmonary condition prevents him from performing his usual coal mine or comparable work. Claimant's usual coal mine work involved underground coal mining.

The exertional requirements of the claimant's usual coal mine employment must be compared with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(c)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

Dr. Simpao opined that Claimant was totally disabled based on the "[o]bjective findings on the chest x-ray, arterial blood gas study, EKG, pulmonary function test along with sumptomatology and physical findings as noted in the report." He provided the underlying clinical findings, observations and facts upon which he based his diagnosis, and they were adequate to support his conclusion. I find that Dr. Simpao's opinion is well-reasoned and well-documented, therefore, it is entitled to probative weight.

Dr. Lombard found that Claimant is totally disabled. He provided the underlying clinical findings, observations and facts upon which he based his diagnosis, and they were adequate to support his conclusion. I find that Dr. Lombard's opinion is well-reasoned and well-documented, therefore, it is entitled to probative weight.

Dr. Younes, a board-certified pulmonologist, noted that Claimant could not perform comparable work in a dust-free environment. However, as previously noted, Dr. Younes did not provide the underlying clinical findings, observations or facts to support his opinion. Therefore, I find that Dr. Younes' opinion is entitled to little probative weight.

Dr. Morgan opined that Claimant is "totally and permanently disabled, mainly because of his age, but also because he has coronary artery disease which is still causing symptoms, . . ., and he also has some airways obstruction. Were it not for his age and coronary artery disease, he could have probably continued working as a pumper in a mine." He provided the underlying clinical findings, observations and facts upon which he based his diagnosis, and they were adequate to support his conclusion. I find that Dr. Morgan's opinion is well-reasoned and well-documented, therefore, it is entitled to probative weight.

Dr. Castle, who is a board-certified pulmonologist, found Claimant to be totally disabled. He provided the underlying clinical findings, observations and facts upon which he based his diagnosis, and they were adequate to support his conclusion. I find that Dr. Castle's opinion is well-reasoned and well-documented, therefore, it is entitled to probative weight.

Dr. Jarboe, who is a board-certified pulmonologist, found Claimant to be totally disabled from a respiratory standpoint. He provided the underlying clinical findings, observations and facts upon which he based his diagnosis, and they were adequate to support his conclusion. I find that Dr. Jarbo's opinion is well-reasoned and well-documented, therefore, it is entitled to probative weight.

Dr. Houser, who is a board-certified pulmonologist, opined that Claimant was permanently and totally disabled due to a severe pulmonary disease. He provided the underlying clinical findings, observations and facts upon which he based his diagnosis, and they were adequate to support his conclusion. I find that Dr. Houser's opinion is well-reasoned and well-documented, therefore, it is entitled to probative weight.

Dr. Baker, who is a board-certified pulmonologist, opined that Claimant is "100% occupationally disabled for work in the coal mining industry or similar dusty occupations." He provided the underlying clinical findings, observations and facts upon which he based his diagnosis, and they were adequate to support his conclusion. I find that Dr. Baker's opinion is well-reasoned and well-documented, therefore, it is entitled to probative weight.

The weight of the evidence overwhelmingly establishes that Claimant cannot perform his usual coal mine employment or comparable work due to his pulmonary and respiratory condition. Therefore, I find that Claimant has established by a preponderance of the evidence that he is totally disabled under § 718.204(c)(4), which is in addition to my earlier finding that Claimant was totally disabled under
§ 718.204(c)(1).

I find that Claimant has established an element of entitlement, namely total disability, which he had not previously met. Pursuant to § 725.309(d), it is now appropriate to determine whether Claimant is entitled to benefits under the Act. Section 725.309(d)(1) mandates that evidence from Claimant's prior claims is part of the record.

Pneumoconiosis:

In establishing entitlement to benefits, the Claimant must prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) *Clinical Pneumoconiosis.* "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis.* "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (Dec. 20, 2000).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence.

For the purpose of subsequent claim analysis under § 725.309(d), the record contains twenty-three properly classified interpretations of six chest x-rays. The x-ray taken on December 4, 1989 was interpreted by an A-reader as positive and a B-reader as negative. The interpretation of the B-reader is entitled to controlling weight, therefore, I find that the December 4, 1989 x-ray is negative. The x-ray taken on May 2, 2002, was interpreted by three dually-qualified physicians as negative. Two other physicians of unknown credentials interpreted the May 2, 2000, x-ray, with one reading it as positive and one reading it as negative. The interpretations of the dually-

qualified physicians are controlling, therefore, I find that the May 2, 2000, x-ray is negative. There are six interpretations of the x-ray taken on December 6, 2000. Five dually-qualified physicians and one B-reader interpreted the x-ray as negative. Therefore, I find that the December 6, 2000, x-ray is negative. There are six interpretations of the x-ray taken on May 11, 2001. Six dually-qualified physicians interpreted the x-ray as negative. Therefore, I find that the May 11, 2001, x-ray is negative. There are two interpretations of the August 15, 2001, x-ray. Dr. Wiot, who is dually-qualified interpreted the x-ray as negative. Dr. Baker, who was formerly a B-reader, interpreted the x-ray as positive. The opinion of the dually-qualified physician is controlling, therefore, I find that the August 15, 2001, x-ray is negative. The last x-ray was taken on July 26, 2001. Dr. Lundquist did not read this film for the purposes of determining the existence of pneumoconiosis, therefore, this x-ray is not considered.

I have determined that all six x-rays are negative for the presence of pneumoconiosis. Therefore, I find that Claimant has not established the existence of pneumoconiosis under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. That method is not available in the instant case because this record contains no biopsy evidence. Therefore, I find that Claimant has not established the existence of pneumoconiosis under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis; § 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, I find that Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides that:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions.

Fields v. Island Creek Coal Co., 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his opinion. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

Dr. Traughber opined that Claimant was suffering from CWP as well as a moderate pulmonary impairment after he performed a physical examination, reviewed Claimant's history, and administered a chest x-ray, PFT, ABG, and EKG. He added that Claimant's impairment was due to cigarette smoking and dust in the coal mines. He provided the underlying clinical observations, observations and facts upon which he based his diagnosis, and they were adequate to support his conclusion. I find that Dr. Traughber's opinion is well-reasoned and well-documented, therefore it is entitled to probative weight.

Dr. Simpao diagnosed CWP based upon his findings on a chest x-ray, ABG, PFT, EKG as well as physical findings and symptomatology. He provided the underlying clinical observations, observations and facts upon which he based his diagnosis, and they were adequate to support his conclusion. I find that Dr. Simpao's opinion is well-reasoned and well-documented, therefore it is entitled to probative weight.

Dr. Lombard, who is board-certified in internal medicine as well as the subspecialties of pulmonary disease and critical care medicine, opined that Claimant does not suffer from CWP. Although he found a moderate degree of COPD, he attributed it to asthma and Claimant's smoking history. Moreover, Dr. Lombard opined that he does not believe that Claimant's work history led to the development of COPD. Dr. Lombard performed a physical examination, PFT, ABG and additional diagnostic procedures. He provided the underlying clinical findings, observations and facts upon which he based his diagnosis, and they were adequate to support his conclusion. I find that Dr. Lombard's opinion is well-reasoned and well-documented, therefore, it is entitled to probative weight.

Dr. Younes, who is board-certified in internal medicine and the subspecialty of pulmonary disease, opined that Claimant has a severe obstructive impairment, which was contributed to significantly by forty-one years of coal mine employment as well as Claimant's smoking history. His opinion was based upon a review of Claimant's medical records at the behest of the OWCP. Although the OWCP requested a narrative report, Dr. Younes only completed a questionnaire. The underlying clinical findings, observations and facts upon which he based his diagnosis are not present in the record, which prevents a determination of whether they were adequate to support his conclusion. I find that Dr. Younes' opinion is not well-reasoned nor well-documented, therefore it is entitled to little weight.

Dr. Morgan opined that there is no objective evidence of CWP. He did note a mild to moderate airways obstruction, but attributed it to Claimant's smoking history. Dr. Morgan also noted a restrictive impairment, but attributed it to the opening of Claimant's chest in connection with his coronary bypass surgery. Dr. Morgan's opinions follow a review of Claimant's medical records. He provided the underlying clinical findings, observations and facts upon which he based

his diagnosis, and they were adequate to support his conclusion. I find that Dr. Morgan's opinions are well-reasoned and well-documented, therefore, they are entitled to probative weight.

Dr. Houser opined that Claimant suffers from severe COPD, which was significantly contributed to by coal and rock dust exposure as well as by cigarette smoking. His opinion followed from a physical examination of Claimant, wherein he performed a chest x-ray, PFT and noted subjective complaints. He provided the underlying clinical findings, observations and facts upon which he based his diagnosis, and they were adequate to support his conclusion. He also relied upon medical literature to support his opinion. I find that Dr. Houser's opinion is well-reasoned and well-documented, therefore it is entitled to probative weight.

Dr. Castle, who is board-certified in internal medicine and the subspecialty of pulmonary disease, concluded that Claimant does not suffer from CWP. He found a moderate degree of airway obstruction, which he attributed to smoking and asthma due to a very significant degree of reversibility after bronchodilators. Dr. Castle issued his report after reviewing Claimant's medical records. He provided the underlying clinical findings, observations and facts upon which he based his diagnosis, and they were adequate to support his conclusion. I find that Dr. Castle's opinion is well-reasoned and well-documented, therefore it is entitled to probative weight.

Dr. Jarboe, who is board-certified in internal medicine and the subspecialty of pulmonary disease, opined that Claimant does not have CWP. He did find a reversible airflow obstruction, which could be seen in a dust induced lung disease, but due to the lack of a restrictive element, he argued that the airflow obstruction arose from cigarette smoking or bronchial asthma. Dr. Jarboe's opinion was issued following his review of Claimant's medical records. He provided the underlying clinical findings, observations and facts upon which he based his diagnosis, and they were adequate to support his conclusion. I find that Dr. Jarboe's opinion is well-reasoned and well-documented, therefore, it is entitled to probative weight.

Dr. Repsher, who is board-certified in internal medicine and the subspecialties of pulmonary disease and critical care medicine, opined that there is insufficient objective evidence to diagnose CWP. He declined to draw a conclusion as to whether Claimant had a pulmonary or respiratory impairment, alleging that Claimant performed with such poor effort and cooperation on his PFTs, that one cannot medically interpret the tests for the presence of any pulmonary disease. Dr. Repsher's report was based upon a review of Claimant's medical records. He provided the underlying clinical findings, observations and facts upon which he based his diagnosis, and they were adequate to support his conclusion. I find Dr. Repsher's opinion to be well-reasoned and well-documented. Due to his reluctance to determine whether or not Claimant suffers from a restrictive or obstructive airway disease, his opinion does not squarely address whether or not Claimant suffers from pneumoconiosis. Therefore, I find that Dr. Repsher's opinion is entitled to a lesser amount of probative weight.

Dr. Baker, who is board-certified in internal medicine and the subspecialty of pulmonary disease, opined that Claimant suffered from CWP, and COPD that was significantly contributed to

by dust exposure and chronic bronchitis based on Claimant's history. Dr. Baker performed a physical examination in addition to a chest x-ray, PFT, and an ABG. He considered Claimant's coal mine employment length as well as the smoking history given by Claimant. He provided the underlying clinical findings, observations and facts upon which he based his diagnosis, and they were adequate to support his conclusion. I find that Dr. Baker's opinion is well-reasoned and well-documented, therefore, it is entitled to probative weight.

Dr. Jarvis, who is board-certified in internal medicine and the subspecialty of pulmonary disease, opined that there is no evidence of CWP. He did find a severe obstructive pulmonary impairment, but stated that it was almost certainly from his previous tobacco habit. Dr. Jarvis then stated that he believes "all of [Claimant's] pulmonary disease can be explained on smoking, COPD and wheezing." His report followed from a physical examination, wherein he obtained a chest x-ray and performed a PFT and ABG. Dr. Jarvis noted Claimant's smoking and employment history. At his deposition, Dr. Jarvis testified that tobacco is the main irritant that causes COPD. He provided the underlying clinical findings, observations and facts upon which he based his diagnosis, and they were adequate to support his conclusion. I find that Dr. Jarvis' opinion is well-reasoned and well-documented, therefore, it is entitled to probative weight.

Drs. Traughber, Simpao, and Baker, all three of who examined Claimant, diagnosed CWP, which falls under the definition of clinical pneumoconiosis. Drs. Lombard, Morgan, Castle, Jarboe, Repsher and Jarvis opined that there is not sufficient evidence to warrant a diagnosis of clinical pneumoconiosis. Drs. Lombard and Jarvis examined Claimant. The physicians issuing opinions finding no evidence of clinical pneumoconiosis hold superior credentials. The weight of the evidence, considering the numerous opinions held by physicians with superior credentials (five are board-certified pulmonologists), establishes that Claimant does not suffer from clinical pneumoconiosis.

Nine physicians opined that Claimant suffered from an obstructive or restrictive pulmonary impairment. Such a diagnosis satisfies the definition of legal pneumoconiosis if the impairment arose from coal mine employment. All nine physicians agreed that one cause of Claimant's pulmonary impairment is smoking, therefore, I find that Claimant's smoking history is a significant contributing factor towards his COPD. Drs. Traughber, Younes, Houser and Baker opined that coal dust exposure was a significant contributing factor to Claimant's pulmonary impairment. Dr. Younes' opinion is entitled to little weight, Dr. Baker is a board certified pulmonologist, and Drs. Houser's and Traughber's credentials are unknown. Drs. Lombard and Jarboe, who are board-certified pulmonologists, opined that Claimant's COPD was due to smoking and asthma, and not from his coal mine employment. Dr. Morgan attributed Claimant's COPD to his smoking and his restrictive impairment to his coronary bypass surgery, but did not rule out Claimant's coal mine employment. Dr. Jarvis, who is a board-certified pulmonologist, opined that Claimants severe obstructive pulmonary impairment is from his previous tobacco habit, but did not rule out his coal mine employment. Thus, five physicians issued an opinion as to whether Claimant's coal mine employment was a significant contributing factor to his pulmonary impairment. Two board-certified pulmonologists expressly ruled out Claimant's coal mine employment. Two board-

certified pulmonologists and two physicians of unknown credentials opined that Claimant's coal mine employment was a significant contributing factor. However, Dr. Younes opinion is entitled to little weight. In light of the two board-certified physicians who ruled out Claimant's coal mine employment, and three physicians, two of whom are board-certified pulmonologists, who limited the contributing factors to smoking and asthma, I find that Claimant has not established by a preponderance of the evidence that his coal mine employment was a significant contributing factor to his pulmonary impairment. Therefore, I find that Claimant has failed to prove by a preponderance of the evidence that he suffers from pneumoconiosis under subsection (a)(4).

Entitlement:

The Claimant, Lastel Lewis, has failed to prove, by a preponderance of the evidence, that he suffers from pneumoconiosis. Therefore, Mr. Lewis is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

It is, therefore, ORDERED that the claim of Lastel Lewis for benefits under the Act is hereby DENIED.

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THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. **A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.**